# HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY COMMITTEE

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| Report subject | **Update on Home First (Intermediate Care) Development across Dorset** |
| Meeting date | 20 May 2024 |
| Status | Public Report |
| Executive summary | To provide an update on Home First (Intermediate Care) development across Dorset to the Health and Adult Social Care Overview & Scrutiny Committee. |
| **Recommendations** | **It is RECOMMENDED that:**<br><br>Committee members are requested to note and respond as appropriate to the update provided, with a recommendation that a further update is presented in twelve months (May 2025). |
| Reason for recommendations | To ensure the Health and Adult Social Care Overview and Scrutiny Committee are fully updated on the Home First development. |

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| Portfolio Holder(s): | Cllr David Brown, Portfolio Holder for Health and Wellbeing. |
| Corporate Director | Jillian Kay, Corporate Director for Wellbeing. |
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| Wards | All |
| Classification | For Update and Information. |

**Introduction**

1. The purpose of this briefing is to provide an update to Committee members on the pan-Dorset programme to develop an effective, recovery focused intermediate care model for all Dorset residents. This is a joint delivery programme across health and social care which brings together the resource and expertise across both sectors to review the pathways and service models for 'step-up' and 'step-down' care and support.

2. The objective is to improve the responsiveness and impact of these services by developing the right mix of community-based rehabilitation and reablement services, and by simplifying the processes by which they can be accessed. This will contribute to better long-term outcomes for people by ensuring they have timely access to high quality recovery services in the community, ideally in their own homes, and by reducing delays in people exiting hospital.

3. There has been good progress in 2023/24 to roll-out a pan-Dorset 'discharge to assess' (D2A) approach but there is more to do to. There are still too many people delayed in the wrong places for too long (acute and community hospital beds) and as a result we have not yet been able to shift the focus of intermediate care towards preventing hospital admission which is where we know there are significant opportunity.

4. The key focus for 2024/25 is to progress at pace the joint commissioning approach needed to deliver a sustainable model for intermediate care that delivered at the right shape and scale to meet the needs of BCP Council residents (with an equivalent focus in the Dorset Council footprint). Delivering this, alongside continuing to target improvements at reducing hospital delays, will enable better flow and outcomes for the whole health and care system.

## Background

5. The Dorset intermediate care redesign (Home First) programme was initially mobilised in March 2020 in line with the requirements of the national pandemic response[1]. The primary objective in this initial wave of the pandemic was to ensure that sufficient acute bed capacity was created and maintained; but it also provided an opportunity for local systems to accelerate and extend work already in train to support a comprehensive discharge to assess approach.

6. The programme has evolved since this time from an 'incident response' programme to a structured programme of improvement and delivery that is focused on improving access to intermediate care services, and thereby reducing the time people need to spend in hospital, and ensuring a sustainable community recovery model is in place for the Dorset population. However, the core objectives remain unchanged:

a) To roll out a universal 'discharge to assess' approach that ensures people can recover and be assessed for their longer-term care needs in the right setting (not an acute hospital)

b) To right size the out of hospital intermediate care offer across health and social care to ensure a sustainable and responsive model of delivery for both step-up and step-down support.

### About Discharge to Assess

7. Discharge to Assess (D2A)[2] is a model of care that supports people to leave hospital as soon as they no longer require an acute bed, and to continue their care and assessments at home or in a community setting. The goal is to provide people with additional time and support for recovery, before making choices about their longer-term care support.

8. Fundamental to D2A is the principle that comprehensive assessment (including assessment under the Care Act 2014) will take place out of hospital, although it is acknowledged that there will be exceptions where it may be required that the assessment be carried out in hospital if deemed essential and/or appropriate. Ideally a conversation with the person about their support needs will take place in a person's own home but can also be in a community or care bed where this is required. The key provider of recovery support in the community will be local intermediate care services.

9. In Dorset, we currently discharge around 85% of people leaving hospital using a 'Discharge to Assess' approach. We ideally want this closer to 95%.[3]

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[1] COVID-19: Hospital discharge service requirements (publishing.service.gov.uk)
[2] Home First / discharge to assess | Local Government Association
[3] The primary reason some will not be discharged under D2A is if we do not have a community service that can meet their needs in the community. This is the often people with the most complex needs.

## About Intermediate Care

10. Intermediate care is a multidisciplinary service that provides short-term support[4] and rehabilitation to people at risk of hospital admission or who have been in hospital. It is focused on helping to people to recover and increase their independence. It is typically grouped into four types of support[5]:
    a. Community-based rehabilitation service which provide assessments and interventions to people in their own homes or in a in care home. This is typically therapy-led and commissioned and provided by the NHS.
    b. Community reablement services which work in a similar way but have a greater focus on helping people to recover skills and confidence to live at home and maximise their independence. This is typically commissioned by Local Authorities
    c. Community bed-based services which support individuals who cannot be safely recovered at home. This includes NHS community hospitals as well as and beds in care homes specifically set up for reablement or discharge to assess purposes.
    d. Crisis response services which are based in the community and provide rapid intervention to people in their own home with the aim of avoiding a hospital admission.

11. Individuals requiring intermediate care may often receive one or more of these services with health and social care working closely together to deliver the best outcomes for individuals. It is often the same community rehabilitation and reablement teams providing both 'step-up' (admission prevent) and 'step down' (supported discharge) care.

12. A refreshed model of community rehabilitation and reablement services has recently been published by NHS England and will form the foundation for the work of this programme in 2024/25[6]

## Outcomes and Benefits

13. A well-designed intermediate care service jointly delivered by health and social care and underpinned by a comprehensive discharge to assess approach will not only lead to better recovery outcomes and experience for the individual but will also wider system benefits for sustainability and use of resources.

14. A recent report published by the County Council Network and Newton[7] quantified these benefits at a national level:
    a) 175,000 fewer older adults (aged 65+) admitted to hospital and instead supported in the community (£0.6bn)

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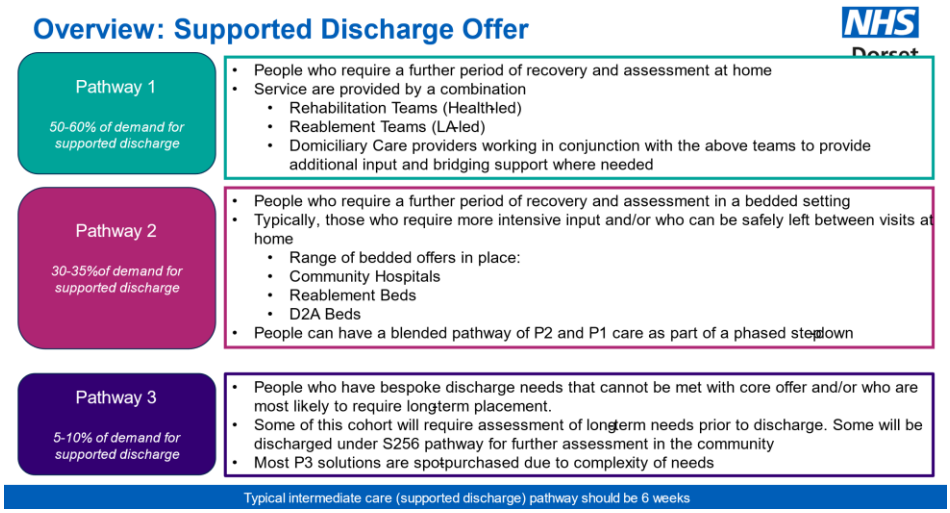
[4] Typically, up to 6 weeks
[5] Intermediate care guide - SCIE
[6] Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge (england.nhs.uk)
[7] Finding-a-Way-Home-CCN-Newton.pdf (countycouncilsnetwork.org.uk)

b) 1.1 million fewer beds days lost to 'complex' discharges, primarily as a result of improving capacity in intermediate care and reducing delays in the discharge process. (£356m saving)
c) 43,000 people could have a more independent long-term outcome as a result of being discharged onto the right intermediate care pathway at the right time (£575m saving)

## Our Current Position

### Current intermediate care offer;

15. There is a broad range of home-based and bed-based intermediate care services available for Dorset residents and which are organised into three main pathways.




16. For BCP residents, most people are discharged one of the following services:

| 1. Pathway one services | 2. Pathway two services |
|---|---|
| • Acute hospital-led interim and bridging services run by University Hospitals Dorset (UHD)<br>• Community-based intermediate care teams run by Dorset Healthcare<br>• Reablement services run by Tricuro on behalf of BCP council.<br>• Rapid response and D2A domiciliary care commissioned by BCP | • Community Hospital beds (208 in total servicing all of Dorset area and run by DHC<br>• 38 beds at Coastal Lodge providing a mix of rehabilitation and D2A beds (run by Tricuro)<br>• 24 D2A beds run by Care South and commissioned by NHS Dorset<br>• 20 beds at Figbury Lodge providing a mix of step up and step down beds, commissioned jointly by BCP Council and NHS Dorset. |

17. Whilst having this breadth of capacity is helpful, the different commissioning and access arrangement contributed to extra complexity and hand-offs between different parts of the service which add to delays.

**Demand for intermediate care in 2023/24**

18. There have been 4,969 referrals for intermediate care step-down support to BCP residents between April 1, 2023, and March 31, 2024. About 73% converted to actual discharges[8] with:

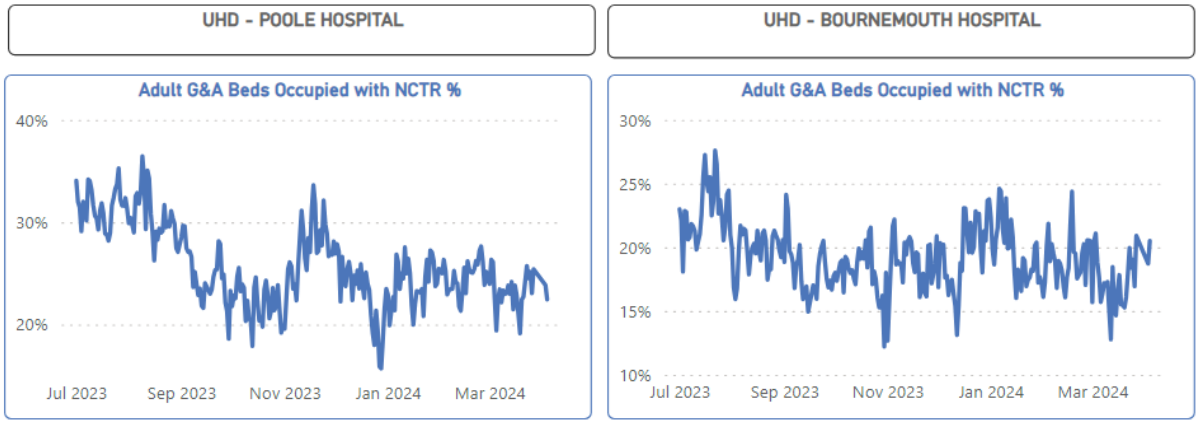
a) 2,524 (65%) being discharged with home-based intermediate care services (Pathway 1)
b) 1,114 (29%) being discharged with bed-based intermediate care services (Pathway 2)
c) 239 (4%) being discharged into long-term care/placement (Pathway 3)

19. Whilst referrals in 2023/24 for intermediate care service were similar to 2022/23, there was an increase of circa four hundred discharges with a higher proportion leaving on Pathways 1 and 3 than in the previous year.

20. 87% of these discharges were from University Hospitals Dorset NHS Foundation Trust, noting that discharges into Pathway 1-3 represent about 13% of the total discharges from UHD.

**System flow**

21. Despite some evidence of in-year improvement in the number of delays wating to leave UHD, the number of people not meeting the criteria to reside in hospital remains stubbornly high with between 20 and 25% of acute hospital beds blocked. This has a negative impact on both acute hospital flow (people waiting in A&E or for planned operation) and wider system flow (people waiting for ambulances); as well as carrying additional risks for the person delayed.




[8] This figure excludes 1,432 episodes that were closed for other reasons e.g. person became medically unwell or died, or person was discharged into a specialist service.

22. There are typically around 150 patients waiting in UHD for intermediate care support at any one time, with the majority of these residing in the BCP area. Whilst we have seen some improvement in time taken to transfer individuals out of hospital to a Pathway 1 or Pathway 2 intermediate care offer, this is not yet at the level we need to consistently maintain flow through all our acute and community spaces.

23. It typically takes circa 8 days for a Pathway 1 discharge from the point at which the person is medically fit to leave hospital and up to 14 days for a Pathway 2 discharge[9]. Our aim as a system is reduce this to below 5 days in the first instance with target aspiration of less than 3 days.

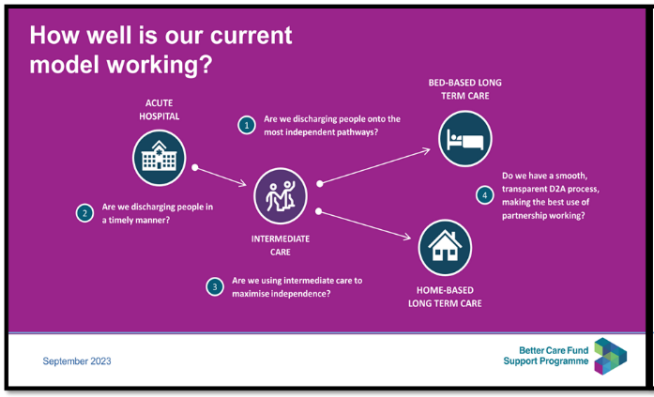
**Our Plan for 2024/25**

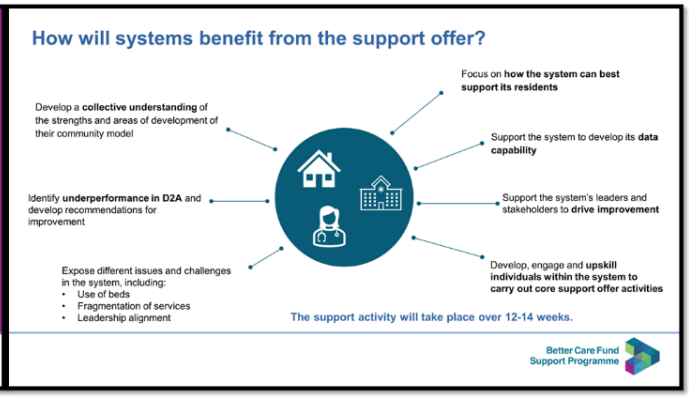
24. Having made some good progress in 2023/24 to improve the responsiveness, it is clear that there is still further to go to deliver the sustained improvement in our discharge to assess and intermediate care offer for all Dorset residents. Our work in 2024/25 will fall into two primary areas:

a) Continued focus on targeted improvement to reduce the length of time people spend in hospital that is not required. This will primarily focus on bringing forward our discharge planning processes and reducing the number of hand-offs and decision points between different partners.

b) A full review and redesign of our intermediate care model that will reduces the fragmentation between the different service offers in terms of how they are both commissioned and provided; and to address the gaps in our current service offer for those individuals with the most complex needs.

25. As a first step, we are about to commence a piece of work with the national BCF support programme to review our current D2A pathway and set the foundations for the redesigned intermediate model. This will be completed by early July 2024 and will include both qualitative and quantitative assessments of our current ways of working.




[9] Circa 69% of all Pathway 1 acute discharges take place within 5 days; this applies to 30% of Pathway 2 transfers currently.

26. In parallel to this, we will continue to drive our targeted improvement work across all health and social care pathway with our focus for the first quarter in:

a) Establishing acute-based Transfer of Care hubs which will bring all the key professionals involved in supporting site on-site in the acute hospital to work more collaboratively in sourcing discharge solutions for people in hospital. This should reduce the length of time it takes to discharge an individual and make better use of the intermediate care resources available.
b) Scaling up the use of Expected Discharge Dates in acute and community beds and using this as lever for earlier discharge planning. This should reduce the length of time it takes to discharge and individual by ensuring all partners start the appropriate planning at the time someone is admitted rather than when they are medically ready to leave.
c) Agreeing a set of standards for how long a person should expect to wait for different parts of their discharge and recovery plan to be completed. This will apply across health and care and support us to better hold each other to account when these standards are not met.
d) Sourcing solutions for a better shared dataset across health and social care partners to help drive timely decision-making and enable us to spot more quickly when things are not happening as we would intend.
e) Agreeing a consistent process senior escalation between organisations at place-level for when operational pressures increase and/or when our standards are not being met.

27. By tackling both these areas in tandem, it is our intention to both achieve a step-change reduction in hospital delays in the first quarter which will in turn release capacity and headspace to focus on our longer-term ambitions for an effective, recovery focused intermediate care services for BCP residents.

**Performance data**

28. The Hospital discharge Adult Social Care Outcomes Framework (ASCOF) were stopped in 2019 when the pandemic started as the hospital discharge process changed. The ASCOFs used to be around delayed transfers of care.
29. Client Level data (CLD) that has been collected since April 2023 gives us data about how many referrals come to BCP Council for support, for people leaving hospital.
30. On average CLD told us that over the last year 99 people received support from ASC to facilitate their discharge from hospital, each month. This number currently remains static.

31. Moving forward the ambition is to have agreed system wide Hospital Discharge data that will be available through the Dorset Intelligence and Insight Service (DiiS), that is provided by all partners within the Integrated Care System (ICS). This work is currently being scoped and data is being mapped from each partner. Project leads are also linked into the south west ADASS reginal work for wider support with this.

32. Better Care Fund (BCF) metrics are reported and performance monitored by the Health & Wellbeing Board. A full report on how we are performing against the BCF targets will go to the next Health & Wellbeing Board meeting and can be shared with Health and Adult Social Care Overview and Scrutiny Committee.

**Complaints and learning**

33. In 2021/22, during the pandemic and when the D2A process was introduced, 9 complaints were received by the council around hospital discharge. These complaints were responded to jointly with health partners as were generally around the new process and how partners across the system were communicating or working together. One of those complaints went onto the ombudsman however was not found at fault, as the person had declined the care that was needed and offered by ASC. Learning was taken from these complaints and an Information and Advice leaflet was designed by the Council and Health to inform people of what to expect from discharge process.

34. In 2022/2023 complaint numbers fell to three and in 2023/2024, there were four complaints. The themes for these cases were generally around fees and funding for their placements from discharge.

35. The Council is working with Healthwatch as they roll out a feedback project around hospital discharge, leaving people with a diary that they can complete to let us know their experiences and what works well and what could be done better.

**Summary of financial implications**

36. The value of the funding for D2A system schemes for 2023/24 is £10.2m, of this £8.3m is funded by Health and £1.9m is funded by BCP Discharge fund.

37. There is further funding in the Better Care Fund dedicated to early support of hospital discharge of which £6.4m is health funding and £2.9m is BCP use of the Improved Better Care Fund grant.

38. For 2024/25 Health have reduced the level of funding for system schemes from £10.2m to £5.1m. BCP is planning to use its £3.1m Hospital Discharge Fund towards higher cost of care and meet the increased demand now imbedded in the base caseload as a direct result of the D2A approach. The Health funding for the Early Supported Discharge schemes in the Better Care

Fund have received an inflationary increase of 5.6% whilst the Government has frozen the allocation of the Improved Better Care Fund grant.

39. The Dorset ICB are minded to allocate £5.1m funding for 24/25 against specific schemes necessary to accommodate the Home First model, however this has not been agreed yet. Some of the schemes are realised in the form of block arrangement like block booked home care hours to provide rapid response in people's homes, or block booked care home beds in Coastal Lodge to provide out of hospital rehabilitation. There are also various staffing roles like brokerage and social work capacity.

**Summary of legal implications**

40. There are no legal implications directly arising from this report. However, issues referenced within the report may require legal advice and support as and when necessary, this includes case specific assessments in accordance with the Care Act 2014 and where appropriate strategic partnership working issues.

**Summary of human resources implications**

41. Important to note that we have operational and commissioning staff who are funded by non-recurrent monies which potentially could pose a risk should the funding alter.

**Summary of environmental impact**

42. Not applicable as this report is for information and update only.

**Summary of public health implications**

43. Improving community-based rehabilitation and reablement services is important for people's maintenance and recovery of independence. The more these services can be provided in the community or ideally in people's homes, is better for longer term outcomes. The length of time a person stays in a hospital bed due to delays to discharge, the greater the risk of acquiring infection and reduced function levels, both of which are important factors in staying well and maintaining independence in later life.

44. Given our demographic change and ageing population, reablement and rehabilitation services are a vital aspect of ensuring integrated care services cater to the needs of our population.

**Summary of equality implications**

45. Equality impact assessments will be completed to support decision-making in relation to redesign and implementation of services under this programme.

46. As described in the previous Home First Programme Overview and Scrutiny Report (January 2021) vulnerable people, including those with long term conditions and/or disabilities, will be impacted by the programme. Prolonged stays in hospital can increase the risk of hospital-related acquired infections

which would particularly impact these groups. We expect that Home First will have a positive impact on getting people home.

**Summary of risk assessment**

47. If there are any unforeseen delays around further work being implemented.

**Background papers**

Published works;

COVID-19: Hospital discharge service requirements (publishing.service.gov.uk)

Home First / discharge to assess | Local Government Association

Intermediate care guide - SCIE

Intermediate care framework for rehabilitation, reablement and recovery following hospital discharge (england.nhs.uk)

Finding-a-Way-Home-CCN-Newton.pdf (countycouncilsnetwork.org.uk)

**Appendices**

None.